



## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor Name and Address:  INTEGRA SPECIALTY GROUP, P.A. 517 N. CARRIER PKWY. STE. G GRAND PRAIRIE, TX. 75050	MFDR Tracking #: M4-09-B009-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:  SENTRY INSURANCE REP. BOX # 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

**Requestor's Position Summary:** "...This HCP beseeches the TDI to rule on this Fee Dispute based on the existing EOB's presented by the carrier to the HCP, along with all the other properly submitted documentation...."

**Principle Documentation:**

1. DWC 60 package
2. CMS 1500s
3. EOBs
4. Pre-authorization letter
5. Medical records
6. Total Amount Sought - \$1494.83

### PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

**Respondent's Position Summary:** "...the carrier asserts that it has paid according to applicable fee guidelines...."

**Principle Documentation:**

1. Response Package
2. Pre-authorization letter
3. EOBs

### PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
8-4-08	99212 99455-VR	\$52.83 divided by 38.087=\$1.387 x \$38.24=\$53.04 N/A (Not Documented/Supported)	\$53.04 \$50.00	\$53.04 \$0.00
11-26-08	99212	\$52.83 divided by 38.087=\$1.387 x \$38.24=\$53.04 - \$28.21 (carrier paid) =\$24.83	\$24.83	\$24.83
12-3-08	97032-GP (x2 units) 97035-GP 97110-GP (x3 units) 97112-GP 97140-GP 99213	\$52.83 divided by 38.087=\$1.387 x \$15.95=\$22.12 x 2 units = \$44.24 \$52.83 divided by 38.087=\$1.387 x \$11.26 = \$15.62 This code not documented as performed-3 units (97110) \$52.83 divided by 38.087=\$1.387 x \$28.77 = \$39.91 \$52.83 divided by 38.087=\$1.387 x \$25.64 = \$35.56 \$52.83 divided by 38.087=\$1.387 x \$61.08 = \$84.72	\$44.24 \$15.62 \$114.84 \$39.91 \$35.56 \$84.72	\$44.24 \$15.62 \$0.00 \$39.91 \$35.56 \$84.72
12-22-08	99080-73	\$15.00	\$15.00	\$15.00
12-29-08 1-8-09 3-23-09	99213	\$52.83 divided by 38.087=\$1.387 x \$61.08 = \$84.72 \$53.68 divided by 36.0666=\$1.488 x \$61.76 = \$91.92 \$53.68 divided by 36.0666=\$1.488 x \$61.76 = \$91.92	\$84.72 \$91.92 \$91.92	\$84.72 \$91.92 \$91.92

1-5-09	99212	\$53.68 divided by 36.0666=\$1.488 x \$37.43 = \$55.71	\$55.71	\$55.71
2-5-09	97750-FC (x16 units/4 hours)	\$53.68 divided by 36.0666=\$1.488 x \$29.09 = \$43.30 x 16 units =\$692.80	\$692.80	\$692.80
<b>Total Due:</b>				<b>\$1329.99</b>

## **PART V: FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation codes provided on or after March 1, 2008.
3. 28 Tex. Admin. Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008
4. 28 Tex. Admin. Code §129.5 sets out the fee guidelines for the reimbursement of workers' compensation work status reports.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 9/16/2008 and 1/08/2009:

- 1 – This procedure is mutually exclusive to another on this date of service-By clinical practice standards, this procedure should not or cannot be performed in the same treatment period
- 1 – Processed based on multiple or concurrent procedure rules
- 1 – Workers Compensation State Fee Schedule Adjustment
- 1 – The charge for this procedure exceeds the fee schedule allowance

Explanation of benefits dated 7/14/2009 and 7/20/2009:

- 1 – This procedure is mutually exclusive to another on this date of service-By clinical practice standards, this procedure should not or cannot be performed in the same treatment period
- 1 – Processed based on multiple or concurrent procedure rules
- 1 – Based on the information available to us, the number of treatments provided to this patient exceeds the number ordinarily required for this diagnosis
- \* After further review our denial remains the same on code 99212, paid Dr. Edward Breeding for cpt code 99455 for dos 8/4/08 \*

### **Issues**

1. Pursuant to Rule 134.203 and Rule 134.204, can the evaluation & management code be billed in conjunction with the treating doctor's review of an MMI (maximum medical improvement) certification ?
2. Did the requestor submit convincing documentation of carrier receipt of the request for the EOBs in accordance with 28 Tex. Admin. Code §133.307 ?

### **Findings**

1. A review of the CMS 1500 forms submitted identifies that on 8-4-08, the requestor billed CPT codes 99212 and 99455-VR. In accordance with Rule 134.204 (j) (6), the treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Act and Division Rules, Chapter 130 of this title. The treating doctor shall bill using CPT Code 99455 with modifier "VR" to indicate a review of the report only, and shall be reimbursed \$50. There is no proclamation within Rules 134.203 or 134.204 that would preclude the provider from billing an office visit code on the same day as an MMI/IR review. The carrier states that denial of code 99212 will remain due to payment to this provider for code 99455 on this same DOS. The carrier did not submit any documentation to support this statement. Payment is recommended for the office visit billed for DOS 8-4-08. The requestor did not submit any report/documentation to support the billing of code 99455-VR. Payment is not recommended for this code.
2. In accordance with Rule 133.307 (c) (2) (B), the requestor shall include within their MFDR request a copy of each explanation of benefits (EOB) relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB. The requestor fulfilled this Rule requirement by way of the submission of a fax confirmation sheet and a signed U.S.P.S. certified form identifying carrier receipt of the EOB request(s).

### **Conclusion**

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$1329.99.

### **PART VI: ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019, the Division has determined that the requestor is entitled to \$1329.99 reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$1329.99 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.130, due within 30 days of receipt of this Order.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

**6-3-10**

\_\_\_\_\_  
Date

### **PART VII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**